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Vol. XV. HALIFAX, NOVA SCOTIA, JUNE, 1903. No. 6

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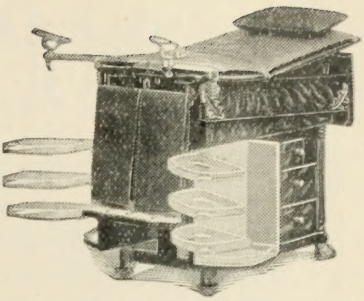

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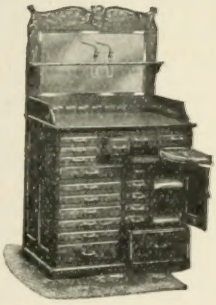

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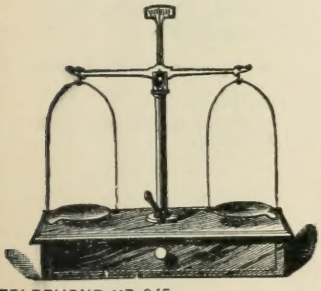

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JAMES ROSS. M. D., C. M., McGill, Lecturer on Skin and Genito-Urinary Diseases.
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The Thirty-Fifth Session will open on Thursday, August 27th, 1903, and continue for the eight months following.

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2ND YEAR.—Organic Chemistry, Anatomy, Practical Anatomy, Materia Medica, Physiology, Embryology, Pathological Histology, Practical Chemistry, Dispensary, Practical Materia Medica.
(Pass Primary M. D., C. M. examination).

3RD YEAR.—Surgery, Medicine, Obstetrics, Medical Jurisprudence, Clinical Surgery, Clinical Medicine, Pathology, Bacteriology, Hospital, Practical Obstetrics, Therapeutics.
(Pass in Medical Jurisprudence, Pathology, Therapetics.)

4TH YEAR.—Surgery, Medicine, Gynæcology and Diseases of Children, Ophthalmology, Clinical Medicine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination, Applied Aanatomy.
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1903.

Medical Society of Nova Scotia.

35 ANNUAL MEETING.

The Annual Meeting will be held in Antigonish, Wednesday and Thursday, July 1st and 2nd, commencing at 2 p. m. on Wednesday. All who intend reading papers or presenting cases at this meeting must notify the Secretary as early as possible.

J. J. CAMERON, M. D., *President,* Antigonish, N. S.

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Maritime Medical Association.

THIRTEENTH ANNUAL MEETING.

The Annual Meeting will be held in St. John, N. B., on Wednesday and Thursday, July 22nd and 23rd.

Extract from Constitution:

"All registered Practitioners in the Maritime Provinces are eligible for membership in this Association.

All who intend to read papers at this meeting will kindly notify the Secretary as early as possible.

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T. D. WALKER, M. D., *Hon. Secretary,* ST. JOHN, N. B.

New Brunswick Medical Society.

The Twenty-Third Annual Meeting will be held at St. John, N. B., in the Church of England Institute Rooms, Orange Hall, Germain St., at eight o'clock on the evening of July 21, 1903.

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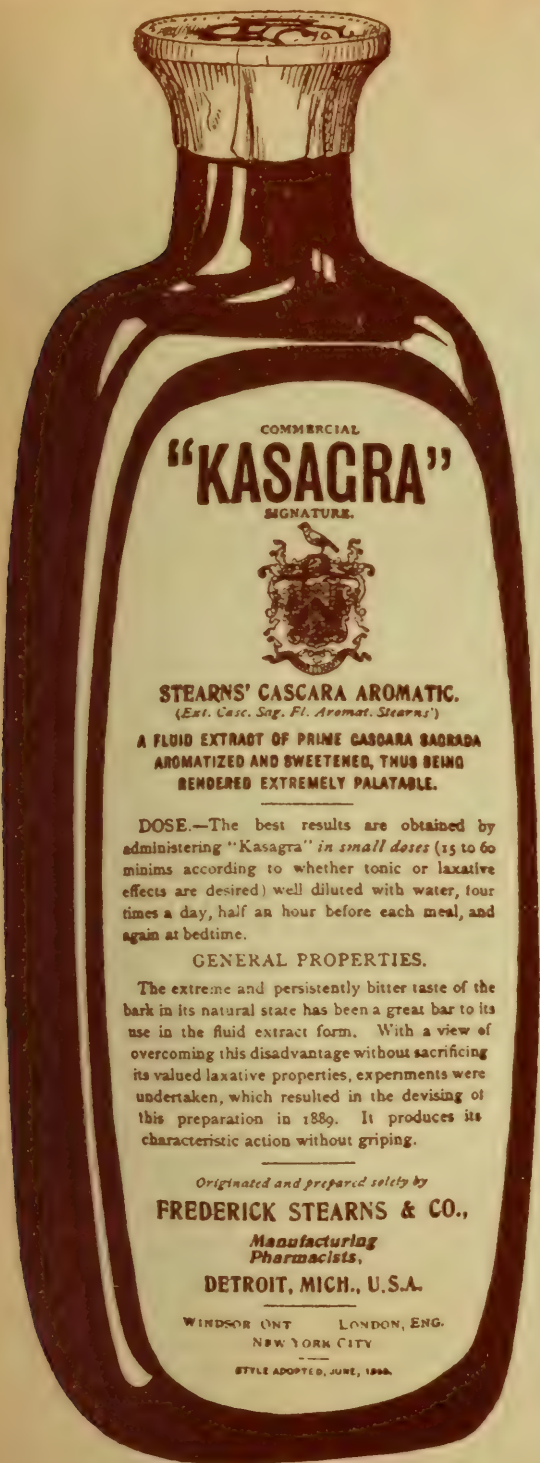
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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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THE
MARITIME MEDICAL NEWS.
A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XV. HALIFAX, N. S., JUNE, 1903. No. 6.

Original Communications.

CHRONIC SUPPURATION OF THE ACCESSORY CAVITIES OF THE NOSE.*

By A. PIERCE CROCKET, M. D., St. John, N. B.

Chronic suppuration of the accessory cavities of the nose is a much more frequent affection than is generally supposed, and of these cavities the maxillary antrum is the most frequently affected.

The five cavities, viz., maxillary antrum, frontal sinus, anterior and posterior ethmoidal cells and sphenoidal sinus, discharge their secretions into the nose through small tortuous canals, which, with the exception of that for the frontal sinus, are badly placed for drainage. To the action of the ciliated epithelium—a continuation of that lining the cavities—is the transmission of the natural secretions of these cavities due, except in the case of the frontal where its dependent position probably plays some part in the transmission.

It is obvious that any pathological condition of the nasal mucous membrane renders the membranes of these cavities liable to disease, either by transmission or obstruction or both, with consequent decomposition in the cavities of the natural secretions.

Investigations during the past few years would indicate that influenza furnishes the largest percentage of cases of accessory sinus suppuration. Among other causes may be mentioned caries or necrosis or the deposition of new bone as the result of periostitis, giving rise to a roughening of the walls of the cavity; foreign bodies, which in the case of the antrum may be carious teeth; ozæna, syphilis, tuberculosis or malignant disease.

*Read before the St. John Medical Society, April 29th, 1903.

These cavities may be arranged according to the situation of their outlets into two series—the anterior and posterior—the anterior series comprising the maxillary, frontal and anterior ethmoidal cells, open into the hiatus semi-lunaris which opens into the middle fossa of the nose; consequently in unobstructed suppuration of these cavities pus will be found in the middle fossa.

The posterior series comprising the posterior ethmoidal cells and sphenoidal sinus discharge their contents posteriorly, and in unobstructed suppuration of these cavities we find pus at the posterior part of the superior fossa, running down over the posterior part of the middle turbinate and into the post nasal space and upper pharynx.

The division into these two series assists us, from the position of the pus, in locating the source of the trouble. For the diagnosis of the individual cavity affected other methods must be employed.

By far the most frequently affected cavity is the maxillary antrum—yet we must remember that other cavities may at the same time be affected and drain their contents into the maxillary antrum, which is acting as a reservoir.

A patient comes to us complaining of an offensive unilateral discharge from the nose. This may or may not be associated with headache, chiefly frontal, more marked in the morning, which may completely disappear by noon. On examination we find on the affected side a turgescent membrane, enlarged inferior and middle turbinates—the latter presenting a polypoid condition or actual polypi, and pus in the middle fossa. Polypi in the nose as in the ear in the vast majority of cases are but symptoms of deeper disease, the recurrence of which, after removal, can only be prevented by the removal of the cause—prevent the suppuration and the repeated use of the snare will be unnecessary.

Having excluded syphilitic ulceration and foreign body, the position of the pus directs our attention to the anterior series, viz., maxillary antrum, frontal sinus and anterior ethmoidal cells. The polypi having been removed by snare or other instrument which enables us to tear them from their attachment—not to cut them—the patient returns in a day or two when hemorrhage has ceased and a better view of the nostril is obtained. The pus is carefully wiped away and the patient directed to hold his head with the affected side upward. The nostril is examined in a short time, and if the pus has re-accumulated we may feel fairly

certain we have to do with at least a maxillary antrum suppuration. The pus is again wiped away and the patient directed to sit with his forehead downward. Neither the frontal sinus nor the ethmoidal cells can drain in this position, consequently if pus runs we know we are dealing with an empyema of the maxillary antrum. In some cases, however, this test gives negative results and we have to fall back on other methods.

Transillumination, particularly in frontal sinus suppuration, has not been a success—the results usually being negative. Its excuse for existence lies in the fact of its confirmatory diagnosis in some cases of maxillary antrum suppuration. It is a well known fact that pus may transmit light, and the maxillary antrum may be filled with pus and yet little or no difference between the healthy and the unhealthy side be distinguishable. In the successful cases of transillumination, as when the antrum contains polypi, the diseased side is much darker than the healthy, and the semicircular ray of light below the eye on the healthy side is absent on the diseased side, as is the pupillary reflex, and the patient with both eyes closed will distinguish the light being turned on and off only on the healthy side. In transillumination we must never forget to previously remove any upper artificial plate which may be present, else our diagnosis may be double maxillary antrum suppuration. Sometimes in transillumination thickened membrane will give a much darker appearance on one side than on the other, and here again transillumination fails us.

The method of diagnosis *par excellence* is the washing out of the cavity suspected either through the natural opening, or in the case of the maxillary antrum through artificial puncture. In the latter case this is done by means of a sharp pointed cannula about four inches long, attached to a piece of rubber tubing and connected with an ordinary syringe. The inferior meatus having been cocainized with a 10% solution of cocaine applied with a pledget of absorbent cotton, the puncture is made immediately below the inferior turbinate about one inch behind its anterior end. The point of the cannula having entered the cavity the patient is directed to hold the head forward, the cavity is washed out, and the presence or absence of pus at once demonstrated. In the case of the frontal sinus a small silver cannula about six inches long, bent in the form of the letter S, with the same attachment as that used for the cannula for the maxillary antrum, may be successfully introduced along the sinus

into the frontal cavity. This opening may be covered by an enlarged middle turbinate—the anterior portion of which should be removed to allow the passage of the cannula. This procedure alone will, on account of aiding drainage by removal of an obstruction, sometimes affect a cure. Having, by this means, washed out the frontal sinus, the presence or absence of pus is readily demonstrated. We are left then with but one cavity of the anterior series, viz., the anterior ethmoidal cells, and we make our diagnosis here by washing out the cavity with the aid of a suitably bent cannula, or by exclusion.

As regards suppuration of the posterior series, comprising the posterior ethmoidal cells and sphenoidal sinus, the diagnosis of the exact cavity affected is somewhat more difficult. In those cases of sphenoidal sinus suppuration where the anterior wall of the cavity is diseased, the diagnosis may be readily made by passing the finger through the mouth and post nasal space to the anterior wall of the cavity, the diseased condition of which can readily be recognized by the softened bone which can readily be broken by slight pressure of the finger. In this way the greater portion of the anterior wall may be removed and the cavity thoroughly exposed and any diseased bone, membrane or polypoid tissue scraped away with a curette or ring knife. In those cases where the anterior wall of the cavity is not softened by disease, the natural opening must be looked for and this in the great majority of cases can only be brought into view by removal of the posterior part of the middle turbinate. This having been done a hooked probe is passed through the ostium into the cavity, which is throughly exposed and any carious bone or polypi recognised. If the disease is confined to the mucous membrane of the cavity, daily washing out with the aid of a suitable cannula will readily affect a cure, but if diseased bone and polypi are present, the extent of the cavity having been ascertained by the hooked probe, the anterior wall is carefully broken down with Grunwald's forceps or other suitable instrument, carefully curetted and daily washed out until the discharge ceases.

Having established our diagnosis of empyema of the anterior and posterior ethmoidal cells, we must here consider the indications for operative treatment. The risks must be balanced against the danger and inconvenience entailed by leaving the disease alone, for in this region suppuration is extremely liable to extend not only to the

antrum and frontal sinus, but also to the orbit and cranial cavity. The resulting polypi, headache and inability to fix the attention will influence us in our treatment. When only a few of the cells are affected we may, with the use of a local anæsthetic, remove the polypi and cut away with Grunwald's forceps or ring knife the walls of the affected cavities, and in this way may affect a cure; but when both anterior and posterior ethmoidal cells are affected a radical operation will be required, and this consists in the complete obliteration of all the cells. A general anæsthetic having been administered, a large Meyers ring knife is introduced into the nasal cavity horizontal to but above the inferior turbinate, care being taken that the ring portion is not pushed too far up. The middle turbinate and the ethmoidal cells which lie under it are carefully scraped away with gentle but firm pressure. As we are almost wholly dependent upon the sense of touch, not being able to see the field of operation, we must frequently insert the finger into the nostril and observe our progress. The diseased tissue will be recognized by its soft succulent condition containing spicules of diseased bone. These are thoroughly scraped away and the nostril packed with strips of gauze to prevent hemorrhage. In some cases the orbit has been opened with the resulting "black eye" for a few days. A few recorded cases of meningitis, as the result of the entering of the cranial cavity, have been recorded, but with attention to the above details this should be avoided.

In speaking of diagnosis of frontal sinus suppuration, I stated that by removal of a portion of the middle turbinate for diagnostic purposes, a cure, in many cases, was affected by the increased facility for drainage which the procedure afforded. This failing we may resort to daily washing out of the cavity where this is practicable. In a certain percentage of the cases, however, we must resort to the radical operation—an operation not devoid of danger, and the indications of which are: (1) severe pain; (2) deficient drainage; (3) bulging of the cavity; (4) external sinus; (5) cerebral symptoms; (6) general ill-health due to the disease.

A general anæsthetic having been administered, a large sponge is placed in the post nasal space. The eyebrow having been shaved and skin cleansed, an incision is made in the line of the eyebrow commencing at the inner side and passing outwards to the supra-orbital notch. This should be carried down to the bone and the periosteum thoroughly divided and detached, when a small opening is

made with a chisel through the inferior wall of the sinus. Having ascertained with a probe the extent of the cavity, which varies in many cases, the opening is enlarged sufficiently to enable its interior to be thoroughly examined. The skin incision is now extended downwards to the level of the inner canthus. The periosteum is detached from the inferior wall of the sinus, in doing which the pulley of the superior oblique muscle will be displaced, causing slight temporary diplopia. The inferior wall of the sinus having been cut away, and any polypi removed, the remaining portion of the cavity walls are examined for caries, perforation, etc., which, if found, must be dealt with. If there is caries of the bony walls and the sinus cavity not too large, it is better to obliterate it, and this may be done with little deformity by removing the anterior and inferior walls with a chisel or bone forceps and thoroughly curetting the remaining wall. A large drainage tube is then passed down the infundibulum—its upper end being fixed to the skin at the inner angle of the wound and the lower end brought out through the anterior nares. The rest of the wound having been sutured, a pad of boracic lint kept wet with solution of boracic acid should be applied and frequently changed. For the first twenty-four hours the solution should be kept iced to prevent swelling and extravasation into the orbit. The sutures may be removed at the end of a week or so, and the drainage tube syringed daily and changed about the fourth day.

For the treatment of maxillary antrum suppuration, the daily washing out of this cavity will also in some cases effect a cure. The antrum is perforated with a small antrum drill, through the socket of the first or second molar tooth or either of the bicuspid teeth. A small spiral is placed in the opening made by the drill, and through this the cavity can be washed out as often as is necessary, at least twice a day, with a saturated solution of boracic acid. In about 50 per cent. of the cases is a cure in this way affected. The opening should not be too large, else particles of food will find their way up into the antrum and may re-infect the cavity.

When there are secondary changes in the lining membrane of the cavity, such as polypi or caries of the antral walls, or when there is a foreign body in the antrum, or it is simply acting as a reservoir, a cure from the above method cannot be expected and we must resort to a radical operation, the indications of which are: (1) distension of the antral walls; (2) where an external sinus communicates with the

cavity; (3) when polypi are present in the antrum, or caries of the walls; (4) when the simpler methods fail to affect a cure. A general anæsthetic having been administered an incision about one inch long is made over the canine fossa at the reflection of the mucous membrane from the alveolar border on to the cheek carried right down to the bone, and the periosteum reflected both above and below the incision. A large opening is then made with the chisel in the anterior wall of the antrum, and the cavity thoroughly explored. All polypi and granulations are removed, and any carious spots of bone thoroughly scraped. Finally, a large opening is made into the inferior meatus and the septum between it and the antrum removed. After completion of the operation the outer opening is allowed to close and the subsequent treatment is conducted from the nose. A modification of the above operation, in which the object sought is the obliteration of the antral cavity, is gaining in favor. By it we avoid the large opening into the nose. Having removed all of the anterior antral wall the antrum is thoroughly curetted—all membrane removed and a strong solution of chloride of zinc applied. The cavity may or may not be packed with gauze for 24 hours. A few granulations form—a membranous covering replaces the external bony wall of the antrum and becomes attached, through the granulations, to the inner wall. Thus we have completely obliterated the cavity and consequently cured the antral empyema.

EXTRA-GENITAL SYPHILITIC CHANCRE.

By George S. Whiteside, M. D., Boston, Mass., Assistant Genito-Urinary Surgeon to the Boston Dispensary; Assistant in Anatomy at the Harvard Medical School.

Extra-genital syphilitic chancres, especially those situated on the face, occasionally come under our observation, and several important questions are forced upon our attention concerning them.

Statistics show that about six per cent. of all syphilitic chancres are extra-genital.*

Of these, by far the larger number occur in women. The most common situation, perhaps, is in the neighborhood of the anus, and next in frequency and, therefore, of importance is the mouth or lips. Of 83 cases of undoubted syphlitic chancre which have come under my observation, 4 only have been extra-genital. After reporting these four cases we will consider briefly some important points in relation to them.

Two of these cases are male and two female.

Case 1. Man. Age 34. May, 1900. Two weeks after a natural coitus, a small papule appeared at the upper border of the pubic hair. This enlarged, became a small ulcer and still enlarging was, when the patient came to me, the size of a half dollar. At that time he had noticed it for ten days. The lesion was a circular ulcer with well defined edges and markedly indurated. The only especial interest in this case is the position of the chancre. The subsequent progress of the case was typical. The superficial inguinal glands on both sides became somewhat enlarged, hard and discrete. A general papular eruption followed in due time.

Case 2. Man. Age 26. February, 1903. Came to me with a well developed ulceration situated in the middle line on the dorsum of the tongue, one inch from the lip. He denied all knowledge of exact mode of infection, although admitting illicit intercourse on several occasions within the previous four weeks. The ulcer was about the size of a 5 cent nickel piece, had well defined edges and a greenish-gray floor. The dorsum of the tongue not involved in

*Morrow's System of Genito-Urinary Diseases. Vol. 2, page 83, 1898.

the lesion was thickly coated with a brownish deposit. The chancre was markedly indurated, the induration extending about one-quarter of an inch beyond the border of the ulcer. The entire tongue was considerably swollen, so that the patient had much difficulty in chewing or swallowing food. The glands on both sides of the neck showed a typical adenopathy, especially on the left.

On account of the uncomfortable position, and owing to the possibility of œdema of the larynx, treatment was begun at once.

The secondary rash appeared late, but was unmistakable. It was most marked on the face and forehead, with a few scattered papules over the scapulæ; none elsewhere. The further progress of the case has been uneventful. Healing of the ulcer took place rapidly, being complete in nine days.

The initial treatment consisted in the injection of 1.5 c. c. of the following solution, once daily for five days: then omitting treatment for three days: injection was repeated once daily for seven days.

The solution used was:—

Hydrarg bicyanid.	0.6
Cocaine muriat.	0.04
Aqua distil	30.

This was injected deep into the pectoral muscle on the right and left sides alternately. After the first fifteen days of this treatment, a course of inunctions with unguentum hydrarg. was begun after the classical plan.

Case 3. Female. Age 28. August, 1898. Came for treatment of a moderate sized, indurated chancre of the lower lip, just to the right of the median line. No great discomfort accompanied this lesion, so a palliative course was followed until the appearance of the secondary rash, five weeks later.

The patient was a married woman, and could not account for infection unless from the tin drinking cup provided in the railway trains. Her husband presented himself for examination, and was found to be free from any signs of syphilis. They had been travelling much in the train during July; she accompanying him on his business trips through the New England States.

Treatment was begun during the secondary stage, and has progressed satisfactorily. She is now entirely well, and in December, 1902, gave birth to a full term infant, which has never showed any signs of syphilis. She was under treatment during the course of the pregnancy.

Case 4. Female. Age 25. June, 1896. Consulted me for syphilis of five months, standing; a practically untreated case, since she had made only infrequent visits to her former medical adviser, and had not carried out his treatment. She was a married woman, and it afterward transpired that her husband was in the secondary stage of an acquired syphilis at the time of her infection.

The primary lesion was a moderate sized, indurated, crusted ulcer of the upper lip near the outer angle of the mouth, on the left side. Examination of her body showed a serpiginous rupia situated between the scapulæ, besides large, discrete ulcers on the chest, abdomen and limbs. Inunction treatment was out of the question because of these many ulcers, and so mercury was given by mouth The chancre healed first and the other sores later, but within three months all had cicatrized.

The further progress of the case is not of importance for this article, except to say that, owing partly to the failure of the patient to strictly follow directions given her, the disease has proved very intractable, and she is still under my care. She has never, luckily, become pregnant since her infection.

These cases may be put into two general classes. The first class are those where the sore is no more inconvenient or objectionable than a genital sore would be. In this class, treatment should be deferred until the appearance of the secondary eruption, which clinches the diagnosis. Case 1 is an excellent sample of this.

Case 2, and in some individuals, case 3, would call for immediate treatment. It is of this class I wish especially to speak here.

All authorities, I think, now agree that it is best to wait until the appearance of such typical signs of the disease that there can never afterward be a doubt as to the diagnosis. In case 2 it was, however, imperative to begin treatment at once to relieve the distress and possible danger caused by the peculiar situation of the chancre. It is very important for us to bear in mind that we should not jeopar-

dise the life or general health or even the reputation of our patient by adherence to the rule of waiting for secondary symptoms to confirm our diagnosis.

It is perfectly true that many cases of so called chancroid are later found to have been true syphilitic chancres without clearly marked induration. I have had three such cases within the past six months. But it is, I think, unusual for an ulcer to seem to be a true syphilitic chancre showing all the classical signs of that lesion, and afterward prove to be an ulcer of a more innocent variety. Therefore when, because of its shape and appearance, and above all when typical induration of its base stamp an ulcer as a true syphilitic chancre, we will rarely, if ever, make a mistake by beginning mercurial treatment early, for the relief of the local conditions due to the chancre. This is especially true with male patients. In women the diagnosis of syphilis is often difficult and obscure; in men it is usually much more clear and easy.

If we are to begin mercurial treatment for the relief of urgent local symptoms, what is the quickest, sure method of administration? Almost all will agree that the hypodermic method is the most rapid way to bring the system under the influence of the mercury. In hypodermic medication we have choice of many preparations.

Calomel is the type of insoluble salts which can be used, and corrosive sublimate the most generally popular soluble one.

The calomel method has many advocates. To my mind the dosage is too inexact. If a given quantity of calomel is deposited in the tissues no one really knows exactly how long it will take to absorb. It is also impossible to even guess how much of the entire amount is absorbed each day. Some books state that abscesses sometimes follow its use. I have tried it in a considerable number of cases without having had a single abscess. Perhaps I did not try it long enough. This objection seems to me of no great moment, but I have abandoned calomel for the more soluble mercuric salts, solely on account of the uncertainty of dosage.

Corrosive sublimate is often useful, easy to procure, reliable and not expensive. I have, however, been perhaps unfortunate or unskilful in its use. In my hands its injection has invariably been followed by severe pain. For this reason alone I have resorted to the

tannate of mercury, and all the other preparations advocated by any one, until about two years ago I found in a medical journal (reference lost) the prescription combining the bicyanide of mercury with cocaine. I have used it in several cases during the past two years with marked success. The pain, after injections of 1 or 2 c. c. of this solution, is very slight. I have never seen abscesses from any mercurial injections. It cannot be recommended for a prolonged course because the surface of the patient's body is not sufficiently extensive to use for this purpose, but for a short time in an emergency there is no doubt of the value of the method.

In Case 2, above reported, this injection proved almost painless, and certainly effective in a short time. Improvement of the condition of œdema of the tongue began within twelve hours after the first injection, and progressive improvement was uninterrupted. In one other case (not here reported because not an extra-genital case) in which I tried this injection, severe abdominal cramps and bloody diarrhœa set in after the first injection, but this has been the only instance of the kind I have observed. Of course, treatment must be interrupted under such conditions for a few days. After the first two weeks of treatment, then the usual routine mercurial course may be instituted instead of the hypodermic method. Then progress will follow conventional or extraordinary lines, depending upon the various aspects of the case.

In general, I believe, and have seen it stated elsewhere, that extra-genital chancres usually precede a grave type of infection. The reason for this no one has satisfactorily explained. Case 4, reported above, is in some ways an example of this. She has recently had considerable trouble with her eyes, so she was sent to Dr. E. R. Williams for consultation. He reports that the left optic nerve shows some changes and a gumma of the pia pressing on this nerve is a possibility. To offset this, case 3 is cured, and has had a healthy child since syphilis was acquired. Her disease was not of an especially severe type. Progress toward recovery was satisfactory at all times during the two and a half years she was under anti-syphilitic treatment. After the first nine months she never showed any signs of active syphilis.

Case 1 had perhaps an unusual persistent secondary rash and all the classic symptoms in sore throat, headache at night, later alopecia, etc., but in other ways his case has progressed satisfactorily.

To sum up then, let us advise :—

1. Where possible delay until the diagnosis is sure before giving mercury.

2. Where dangerous, destructive or disfiguring chancres demand immediate treatment, give a soluble mercuric salt hypodermically until the urgent symptoms are relieved. Then resort to some more conventional method of administration.

ABORTION.

By John McDonald, M. D., St. Peter's, C. B.

Abortion is the premature expulsion of the non-viable ovum, either the result of natural causes or criminal interference.

Abortion and miscarriage are strictly synonymous, notwithstanding the popular belief that the term abortion is restricted to the criminal interruption of pregnancy: whilst miscarriage is confined to the spontaneous, resulting from natural causes, occurring within the first seven months of pregnancy, before the complete development of the placenta. Premature labor is the interruption of pregnancy in the last two months when the fœtus is viable and formation of placenta is completed. Miscarriage is often underrated, not even receiving the attention of the family physician, but is confined to the tender mercies of the midwife; yet labor at term may be left far more readily to the powers of nature, inasmuch as labor is a physiological process and abortion is a pathological one. At term we find preparatory changes in the maternal and fœtal parts. The separation of the membranes is facilitated by fatty degeneration of the decidua serotina. The uterine muscle enlarges, its fibres increase and strengthen for the ordeal: but in the early months no such conditions exist.

The causes of spontaneous abortion are chiefly due to pathological changes in the maternal system, general and local. These causes are by far the most important to the practitioner as being amenable to treatment. Causes acting through the system are diseases,—(*a*) acute and chronic, (*b*) neurotic, acting through the nervous system, (*c*) physical or traumatic. (*a*) Diseases, acute and chronic, on the part of the mother, interfere with the nutrition and development of the ovum. In general, whatever predisposes to a vitiated condition of the blood, resulting in malnutrition, may lead to abortion, whether it be an anæmia, the result of disease or lack of food, or the mode of life, or the locality in which the sufferer lives. (*b*) Neurotic causes; during pregnancy—that stage of increased uterine activity and increased growth—we find a corresponding increased nervous excitability, and

responding violently to the slightest cause, which would arouse no reaction during normal conditions. (*c*) Traumatic influences are comparatively rare as a cause of natural abortion, and it is true of these as of every other cause that existing conditions govern the issue.

Spontaneous abortion is generally ushered in with hemorrhage, rigors, feverishness, rapid pulse, nervous disturbances and lumbar pains. These symptoms are rare at all times, and usually wanting in the earlier months. The pain and hemorrhage may be quite severe, or at times slight, but the period of expulsion is well marked when the pain and hemorrhage cease.

Dysmenorrhœa, menorrhagia and fibroids may simulate abortion. In dysmenorrhœa the pain is relieved by the discharge, whilst in abortion, on the contrary, as the flow increases with the dilatation of the cervix and separation of the ovum, the pain increases. In dysmenorrhœa the pain is ovarian, whilst in abortion the pain is uterine, referable to the cervix during dilatation and to the fundus during expulsion. Flowing fibroids may simulate that of abortion, but the aborting uterus is greater in size than the congested menstrual organ.

The treatment of abortion divides itself into prevention and expression. In the preventive stage we find the use of hygienic measures is more important than the employment of drugs. If previous abortions are known to be due to syphilis, endometritis or uterine displacements, these conditions must be relieved by the proper remedies, if there exists no apparent cause for the interruption of gestation. The patient must be placed in a well ventilated apartment, as fresh air is a necessity and should be plentifully supplied. The food should be light, but nutritious and palatable. The mind should be set at rest as far as possible in respect to household and other worries, and particularly directed from the thought of uterine disturbance. Opium is the all important drug in this stage, and should be given in grain doses, to which acetate of lead may be added. The bromides are of great service in soothing irritation and restlessness. Fluid extract of viburnum is very valuable as a uterine sedative, allaying irritation and checking hemorrhage.

Where abortion is inevitable the treatment is radically changed, the object is now to complete delivery. Measures must be directed to the avoidance of hemorrhage, the thorough delivery of the ovum and

appendages, and the prevention of inflammation and septicæmia. The latter accident is to be prevented by the most rigid asepsis of the patient and attendant. For the prevention of hemorrhage the tampon is all important, supplemented by teaspoonful doses of fluid extract of ergot; but if there is reason to believe that portions of the membrane are in the uterus, this drug should not be used as the contraction of the os uteri may imprison materials which then become septic. The uterine cavity is to be cleared by the use of the fingers of the attendant, or by means of the curette. After removal of the membranes the uterus should be douched with a two per cent. solution of creolin in warm water, about a quart being used. After treatment, small doses of ergot and quinine, and vaginal antiseptic irrigations, or uterine if needy, and the maintenance of perfect rest for one or two weeks, or longer if possible.

Selected Articles.

SOME DEVELOPMENTS IN THE THERAPY OF IODOFORM.*

By J. J. Gaines, M. D, Excelsior Springs Mo.

1. *History.*—Briefly speaking, iodoform was introduced into the therapeutic family in 1837, in London and Paris. I have no record showing its medical use at that time; it may have been utilized as a surgical dressing, or some ambitious inventor may have been looking for an ingredient for the construction of a Chinese stinkpot to be used for purposes of defense. I have no doubt of its giving perfect satisfaction, when put to either use.

During the past three-score years iodoform has varied in its degree of popularity, its extremely offensive odor making it the dread of laity and physician. Scores of so-called odorless substitutes have clamored for recognition at our hands, but we are forced to admit their inefficiency as compared with the original. In this brief treatise I shall embody a plea for the continued employment of this valuable drug, until science can offer us one which is of more value to us in the serious ailments of mankind which I shall mention later.

2. *Characteristics.*—Iodoform is produced by the action of iodine in the presence of alkalies, upon alcohol, aldehyde, ether, acetic ether, methylic alcohol, and in minute quantities when acting upon carbohydrates or proteid compounds. Its formula is CHI_3. It occurs in yellow hexagonal crystals, with odor and appearances instantly recognized and unnecessary to describe. It is insoluble in water, yet imparts to it a perceptible odor and taste. Attempts to mask the odor will either fail, or deprive the drug of its specific action. I shall not attempt to discuss the means of combating the disagreeable odor, as I consider them valueless. Iodoform is volatile, and should be kept in well-stoppered bottles, and in a cool place.

3. *Physiological Action.*—In its original state, applied locally, iodoform is mildly antiseptic, sedative, and in excessive quantity toxic, the poisonous agent being iodine. Internally, in dose of less

*Read before the Mississippi Valley Medical Association, Oct. 16, 1902.

than five grains, it exhibits its local action plus a decided antiseptic and alterative effect, the two latter being the result of the rapid and easy liberation of large quantities of free iodine. It is readily acted upon by the gastrointestinal fluids, and so far as I have observed, without deranging them in the least, and liberating the highest percentage of free iodine of any compound at our command. After administering five grains we may note the appearance of iodine in the urine in two or three hours, and which will remain apparent for several days. This proves to us that easy saturation by the drug is followed by protracted elimination, giving us prolonged contact of the remedy with the disease.

4. *Toxicology.*—There is so little difference between iodoform poisoning and that of iodine that it it unnecessrry to discuss it. In the therapy as herein proposed, the problem of poisoning need not enter.

5. *Modes of Administration.* The use of iodoform by inhalation is too important to be neglected. I have used an improvised and crudely arranged apparatus for the nebulization of iodoform emulsion, and have obtained the most happy results in the diseases where indicated, and I anxiously await the time when our inventive genius will give us a perfect nebulizer, especially one that will enable us to utilize heat in connection with the apparatus.

Internally I administer iodoform in a well fitting capsule. The dose I employ is rarely over one grain, and repeated as often as the case demands. Overdosing will disagree with some stomachs, owing to the rapid liberation of iodine. If iodoform be given with subnitrate or salicylate of bismuth, or with prepared chalk, it will be better borne. The bowels should be kept gently opened with seidlitz powder, or any of the magnesia preparations. Phosphate of soda is very useful in this connection.

Iodoform should never be prescribed with any compound of mercury, or with any opiate. In the former case a poisonous iodide will result, and in the latter it is sure to derange the stomach by opposing effects. The chief drugs that I have used as synergistic with iodoform are quinine sulphate, bismuth subnitrate, and bismuth salicylate.

The common uses and modes of giving iodoform I shall not take your time in discussing: the well know suppositories in rectal inflammation, the emulsion in chronic cystitis, and the dressing in tubercular osteitis and other surgical affections, I am content to pass by with mere mention.

6. *Therapeutic Uses.*—By inhalation I have relieved permanently the most obstinate forms of laryngitis and bronchitis, the acute form yielding in from three to six sittings of ten minutes each, and this with a very crude home-made apparatus. Chronic forms yield readily with systematic inhalations, and I believe, from experience, that iodoform in emulsion is a specific in the treatment of bronchopulmonary affections, not excepting the tubercular, if taken in time. Again urging the production of a good thermo-nebulizer, I pass to the internal uses.

In subacute and chronic typhlitis, perityphlitis, and non-operable cases of appendicitis, I have used iodoform in capsule, with salicylate of bismuth and quinine, three or four times daily, with very satisfactory results. I am accustomed to keep the bowels open in these cases with a mixture of olive oil and glycerine, and I find that the benefits of using these agents without the iodoform are not permanent, and hence not satisfactory. Under treatment as outlined, the infiltration and soreness disappear in from three weeks to as many months, and a very grateful patient is almost always the result.

In tubercular peritonitis, after having failed with guaiacol, creosote, cod-liver oil, and the hypophosphites, I have been entirely satisfied with the administration of iodoform and quinine sulphate. The hectic fever and sweats disappeared, and I have been able to discharge the patient in from one to two months, able to return to his business. Just here I may say that I believe iodoform to be a specific in tuberculosis, if we but acquire the art of properly applying it. It is well worth our most earnest endeavor, in combating this most serious enemy of mankind.

In tertiary syphilis, and syphilitic cirrhosis of the liver, I have noted some good results, and I may say in this connection that I unqualifiedly condemn the use of mercury in any of the later stages of syphilis. What cannot be done with the saturation of the patient-

with iodine cannot be done at all. Iodoform has proven of no less value than iodide of potassium, and in many cases has acted more rapidly, giving lasting results.

In the great majority of acute or chronic diseases of the intestinal canal, whatever their origin, iodoform approaches the nature of a specific, being sedative, alterative and germicidal. I have employed it in small doses, one half grain, in typhoid fever in the first and second weeks, and believe the severity of the later weeks was rendered much less. In all ulcerative diseases of the intestinal tract I use iodoform in capsule with same form of bismuth, and am rarely disappointed in results. In tubercular dysentery I am convinced that it is the only thing that approaches the nature of a specific.

In pulmonary tuberculosis I beg to append the following, clipped from the *Journal of the American Medical Association*, and which coincides materially with my own experience: "Iodoform in Pulmonary Tuberculosis: S. S. Cohen, in *American Medicine*, states that iodoform ranks as one among the limited number of drugs which have proved valuable in the treatment of tuberculosis. No other iodine compound, according to the writer, has yet been brought forward which takes its place. Its chief value, he states, is in cases presenting signs of infiltration without softening; but if limited softening be present in one portion of the lung, the drug is of service in combating the extention of infiltration elsewhere. To be beneficial in the highest degree iodoform should be given in gradually increasing doses over a long period. To begin with, one-half a grain or less may be given thrice daily after meals, and very gradually increased to a point of tolerance. In the course of two or three months a daily dose of nine or ten grains will have been reached, which may then be pushed more rapidly until fifteen grains daily are given. A good way to administer it is in capsule form (three to five grains), mixed with balsam of Peru as an excipient. If necessary a digestive agent may be added, or a dose of essence of pepsin may be given an hour later. If deemed advisable, arsenic iodide may be combined with the iodoform, they being chemically compatible and therapeutically synergistic. No one, according to the author, who has persisted in its continued use, will forsake it for any of the transient fads of the day."

In chronic Bright's disease, where an iodide is indicated, whether syphilitic or tubercular, iodoform has proven of great value in my

experience of ten years' frequent meeting with such disease. The alterative dose, one-half to one grain three times a day, is quite sufficient, and will be followed in the majority of cases by great relief in ten days to two weeks. I am convinced that iodine is the best renal alterative at our command, and iodoform the best combination. It is almost without an equal in the flatulence that is often an accompaniment of uremic poisoning, where salol is absolutely harmful. Indeed, I have abandoned the use of salol as an intestinal antiseptic and substituted iodoform instead, and have no reason to regret it.

Having mentioned these fragmentary portions of the experience I have had in the somewhat unusual uses of iodoform, I submit to my fellow practitioners that we have in this pharmaceutical outcast one of the most powerful agents for the relief or cure of the most serious diseases of mankind. Its one objectionable feature, the unpleasant odor, is not a sufficient reason for its being discarded, and I realize that we are too liable, in our mad rush for new remedies, to forsake the old and tried for the new and many times dangerous compounds that are offered us.

I append a few cases in support of the foregoing arguments, which have been so imperfectly presented:

Case 1.—Tubercular peritonitis. Patient aged thirty-two, white; male; occupation, farmer. Marked tubercular history. Diagnosis made prior to my seeing the patient by two prominent physicians, with whom I concurred.

Symptoms, briefly: Emaciation, marked gastric disturbance; loose, irregular bowels; hectic fever and night sweats. Spinal nerves irritable, especially in the cervical region. Patient could not turn the head without turning the entire body. General neuralgia, which he called rheumatism. He had the disease about eight months.

For six weeks I used guaiacol carbonate, cod-liver oil, creosote in capsule and quinine. I then gave him a six-ounce bottle of syrup of hypophosphites, all without any amelioration of the symptoms or abatement of the fever. I then gave him powdered iodoform, gr. xij; quinine sulphate, gr. j; bismuth salicylate, dr. jss; M. et ft. caps. No. xxiv. Sig.: One to be taken every three hours. When he had finished this prescription he was more comfortable in every way, and I renewed, giving grain doses of iodoform. I discharged this patient in six weeks, able to resume his work.

Case 2.—Called in emergency to see Mrs. A——, aged thirty-eight, who was visiting the Springs in search of health, and whom I had never previously seen. Patient presented the following symptoms: Edema to above knees, pulse 140. Respiration rapid and shallow. Spasmodic vomiting, with intermediate convulsions and coma. Axillary temperature 105 (no previous fever). General appearance of the skin, icteric and dry. Pupils equal and responded feebly to light. Unable to protrude tongue, and soon lapsed into continuous stupor. My diagnosis, uremic coma. Prognosis, death at any moment.

The husband stated that no physician had ever given him an idea of what was the matter with his wife, that they had said it was baffling, might be cancer of the liver, or "female complaint;" and my information concerning the case was very meagre at that time, so I treated symptoms as best I could. I discarded pilocarpine and gave tincture aconite root in drop doses every hour, pouring it down the unconscious patient. In twenty hours the fever had abated and semi-consciousness returned. I catheterized the patient, getting about a pint of albuminous urine.

When able to swallow I gave her acetanilid gr. ij., powdered iodoform gr. j., quinine sulphate gr. j; such a dose in capsule every two hours. I gave the iodoform to sterilize the bowel, which was extremely tympanitic and sore to the touch over abdomen. When fever subsided I excluded the acetanilid and continued the iodoform and quinine in the same dose, while the patient remained under my care.

Result of treatment: Patient left her bed in two weeks; in four weeks walked about the town where she chose. The edema disappeared, and she left my care in seven weeks, able to attend to her housekeeping duties. Some albuminuria, however, remained.

I am informed that she employed an osteopath after returning to her home, and some months later died, possibly of nephritis. I mention this case to show the apparent antagonistic action of the iodoform to the progress of the disease, arresting the symptoms almost at the fatal issue, and postponing it for some months.

Case 3.—Chronic catarrh of cæcum, of twenty years' standing. Patient has been using the following formula for four months, and declares that it gives him more comfort than any remedy he has tried:

Bismuth salicylate.....5 grains.
Bismuth subnitrate.....4 grains.
Powd. iodoform.....1 grain.

M. et. sig.: One such capsule between meals and at bedtime.

In this case I gave no other medicine, except to keep bowels regular with olive oil and glycerin. Judging by his personal feelings the patient hopes for ultimate cure.

Case 4.—Acute typhlitis, severe. Called in consultation; the physician in charge making diagnosis of acute appendicitis, and asking for operation. I took the conservative course, and used expectant treatment, opium and high rectal enemata. When acute symptoms abated I gave quinine sulphate 3 grains, powdered iodoform 1½ grains, in capsule, and directed one such to be given every three or four hours, and keep bowels easy with olive oil and glycerin. Patient recovered in six weeks, and has been in perfect health two years. I do not claim a rapid result, but a complete recovery leaving no sequelæ.

Case 5.—Severe subacute bronchitis, which resisted the usual remedies. Patient aged forty; marked tubercular history, his only two sisters and brother dying of the disease. This patient was not robust, and exhibited severe cough, low fever, and blood-streaked expectoration. Unfortunately I did not examine the sputum.

Four inhalations of ten minutes each cured the patient without any other medicine. Inhalant, iodoform emulsion nebulized by heat. There has been no return of the symptoms for the past three years.

Emulsion: Iodoform, muc. acacia, ol. terebinth, glycerin, castor oil.

Case 6.—Diagnosis, typhoid fever. Patient white, female, aged twenty-three. Axillary temperature at onset (about middle of first week when called), 105°. The rose-colored spots were typical during the course, and the teeth were covered with sordes. Tongue typical of typhoid, and diagnosis unquestionable.

When nature of disease was thoroughly apparent to me, I gave a capsule containing powdered iodoform gr. j. bismuth subnitrate gr. iij, quinine sulphate gr. j; such a dose every three hours. Bowels kept easy with saline water. Turpentine stupes over abdomen, antidyretic cool sponging.

Under treatment the temperature steadily declined from the first, and did not exhibit the usual erratic curves so prominent under other methods of treatment. Tympanites gradually abated, and gave little cause for concern. At the end of the second week I considered the general toxemia under perfect control. There was no delirium and no dicrotic pulse, but a barely noticeable subsultus.

I withdrew the iodoform capsule at the middle of the third week, with a maximum temperature of 99°, and completed my work with small doses of bismuth and zinc sulphocarbolate.

I do not claim for this an abortive treatment of typhoid fever, but I believe it will keep off the dangerous phenomena so often exhibited and render the patient's situation safe, much more comfortable, and materially shorten the attack. And I have never known troublesome sequelæ to follow this treatment.

In conclusion, I may say that I considered all the foregoing cases to be severe in character, and to be crucial tests for any form of treatment. And I submit that adding the *internal* uses of iodoform to its many external applications, it is one of the most *useful* (if not ornamental) agents of the Pharmacopœia at our command in treating serious disease.—*The Medical Age.*

Presentation and Address to Dr. S. M. Weeks.

Pressure upon our space prevented us from reporting in our last number a very pleasing function, which took place at the home of Dr. S. M. Weeks, of Newport, on April 11th, when he was waited upon by a number of his professional friends with a presentation and address in celebration of his completion of fifty years of practice in Newport. Congratulatory letters were read from old friends who were unable to be present, among whom was the Hon. D. McN. Parker, the venerable and beloved Nestor of our profession, who was himself a few years ago the subject of a similar jubilee demonstration, and who, though now living in placid retirement, amid "honour, love, obedience, troops of friends," still takes a lively interest in everything relating to medical life and work.

The presentation took the form of a solid silver tea service, suitably engraved, and the address was as follows:

April 11th, 1903.

To S. M. Weeks, Esq., M. D.,

Dear Doctor Weeks:—

We, a few of your very many friends, beg leave to take this opportunity to congratulate you in this your year of jubilee in the ranks of the medical profession.

A few days over fifty years ago the College of Physicians and Surgeons, New York, sent you forth on that mission which ever since then you have so faithfully performed.

First, we wish to reverently express our thanks and gratitude to Almighty God, the Guide and Father of us all, who has so mercifully and signally preserved your health and strength, so that though your three score and ten, your "eye is not dim nor your natural force abated," and you yet retain the vigor of your intellect and soundness of your judgement, so much so that those of us near enough to you are glad to avail ourselves of your advice and matured experience in our times of perplexity. We gladly avail ourselves of this opportunity to express our appreciation of your honorable and upright conduct in your relations to your fellow practitioners, which has

marked your long years of practice. When young and inexperienced, then those of us who knew the value of your helping hand with assistance in times of need, so modestly and quietly given, and to all of us who live in this county, you have shown by your life and conduct as a physician, a knowledge of those high ideals of professional ethics which we earnestly wish all could have followed, and we consider it no flattery to you and no expression of weakness on our part, to say to you how much we believe your professional life and conduct has done to keep up the standard of professional honor and duty in this part of the Province, in this age of competition and struggle for success.

It is impossible to reflect on the half century of practice which you have done, without realizing in some small degree the immeasurable good it has been your privilege and duty to bestow on this community, in which you have lived as the trusted physician and the tried friend in so many homes for so many years. It must be a solace and gratification to you to know that you are respected and beloved by all classes over a larger extent of country than probably any other physician in Nova Scotia.

Honored and respected by your medical brethern, beloved by the people, we rejoice that you are still in the harness and able for active and vigorous work.

Allow us again to congratulate you on the attainment of your jubilee in medicine, and to sincerely wish that you and Mrs. Weeks may be long spared to continue the good work you have so long pursued.

Will you favor us by accepting this small gift as a token of our affection and regard.

D. McN. Parker, M. A. Curry,
F. N. Burgess, E. A. Kirkpatrick,
J. B. Black, J. D. Mosher,
C. J. Margeson, C. H. Morris,
John Stewart, Bret Black

THE
MARITIME MEDICAL NEWS.
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Editorial.

PROFESSIONAL EXAMINATIONS OF THE PROVINCIAL MEDICAL BOARD.

In accordance with legislation, passed in 1899, and which came into effect July 1, 1902, applicants for registration are required to comply with a new condition, viz,, an examination in the various branches of the curriculum conducted by examiners appointed by the Board. As was to be expected an unusually large number of candidates sought to obtain registration before the new law came into operation. Since then there has been a marked falling off in the number of applicants. There were no candidates at the September examinations of last year, and at the April examinations of this year 17 candidates were present, mostly recent graduates of Dalhousie. All but one passed. It may not be amiss before commenting upon the new principle adopted by the Board, to refer briefly to the legislation of the past in respect to the practice of medicine and the requirements for registration.

Previous to 1828 there were no restrictions upon the practice of medicine in Nova Scotia. In that year a short Act was passed delaring it unlawful for any one to practice medicine without a diploma from some medical school or a license from the Governor, obtained after examination before persons appointed by that authority.

No change was made in the law until 1856, when a Registration Act was adopted.

All practitioners were required to appear personally at the Provincial Secretary's office and have their diploma or license registered in a book kept in the Secretary's office. By this Act unregistered persons

in addition to being unable to recover fees for services could not hold provincial appointments, and were liable to a fine of five pounds for every offence.

In 1872 "The Nova Scotia Medical Act" was passed. Under its terms the Provincial Medical Board was established. The act also makes provision for the appointment of a medical man as Registrar, and the annual publication in the *Royal Gazette* of a register of the names and qualifications of all authorized practitioners. A compulsory preliminary examination was at the same time established, to be followed by a four years' professional course with a prescribed curriculum of study. Professional examiners were also appointed to examine candidates with incomplete or unsatisfactory credentials, and to grant the Board's license.

As already stated the Act of 1899 makes a professional examination compulsory.

At first glance it seems unnecessary and decidedly unfair to compel men who have obtained qualifications from reputable schools of medicine to submit to the worry and additional expense of another examination before obtaining authority to practice.

Not one substantial argument could be brought forward to support the change were the Medical Board of Nova Scotia taking the initiative on this question, but when we find the principle of a state examination in operation in all of the other provinces of the Dominion of Canada the matter assumes a different aspect. As a matter of simple justice to its own licentiates the Medical Board should not allow Nova Scotia to be a dumping ground for men who have failed to qualify for practice in the other provinces of Canada.

THE SUCCESSFUL PHYSICIAN.

We take pleasure in calling the attention of our readers to the address, which will be found on another page, presented to Dr. S. M Weeks, of Newport, a few weeks ago, on the celebration of his jubilee as a practitioner. A perusal of this address and a consideration of the circumstances connected with it may well give rise to some reflections. These are days of high pressure and competition in every line of activity, and medical life is not excepted. Even the

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—*The Medical Times and Hospital Gazette.*

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most desirable positions in the profession are subject to geat stress and strain. Our relationships with each other are often in unstable equilibrium, and we all suffer more or less from the evil influence of dark places in our profession full of the habitations of horrid commercialism. Perhaps the most disquieting thing in a survey of the position is the feeling, or fear, that with the passing of older methods of practice, the old ideas of professional courtesy and honor may become obsolete.

The public is never weary of gibing at "medical etiquette," as if the rules of good behaviour were not the same in the medical world as in every day life. They do not take the trouble to understand the application of general rules to our particular cases. But are we not often ourselves to blame for these jeers and gibes of the unthinking public? Do we not sometimes make clean the outside of the cup and neglect the quality of the milk of human kindness within it? The bed-rock of medical ethics is the same foundation as the law of courtesy among men, the golden rule to do as we would be done by. It is good practice to try and put ourselves in the other man's place. It is sharp practice to try and get into his place—and shut him out.

If we try to place ourselves at the other man's point of view we may find many reasons for seeing as he does, and we shall be less likely to heed the detractions of gossips or of those unwholesome persons who try to curry favor with one doctor by misrepresenting another.

We all make good resolves, but we are all apt to think it is "the other man" who is to blame. We should remember the saying of a Thomas à Kempis, "omnes fragiles sumus, sed tu neminem fragiliorem te ipso tenebis."

We know what the cynics say, and we see the success of the wicked, and perhaps to many of us there come times when, whatever we may think of our physic, we are tempted to say "throw ethics to the dogs," and look out for Number One. But this is not the way to success. What does it profit a doctor to gain a fortune, and lose himself? What is success for a doctor? Is it not, by the blessing of God and the faithful discharge of duty, to win the esteem of his colleagues and the gratitude and respect of his patients? The doctor who has not won these has lost his life. He may be a parasi-

tic outgrowth, he may fungate into an auriferous excresence, but he has no part in the sap and fibre of the tree; he is but a *caput mortuum* in the goodly fellowship of "the Faculty."

So that it is pleasant to be reminded that there are men who have not forgotten their Hippocratic oath, men whose golden rule has not been the heaping up of gold, men too proud in the pride of a noble profession to stoop to meanness, who are happier in assisting a colleague than in filching from him his reputation and his patients.

For fifty years Dr. Weeks has practised his profession in Newport: fifty years of country practice. Most of us know something of what that means; but how many can know it for half a century. There are over five hundred names on our register, but only eight of these stand for fifty years of practice.

Weary days and watchful nights, the dust of summer, the snow-drifts of winter, and between them the endless miles of mud, (Hants County mud too!) and after fifty years of it, the glory of success. For his old patients and their children, and children's children look up to him with gratitude and affection, and his professional brethren love him as their friend and the soul of honor. Long live Dr. Weeks!

THE MARITIME MEDICAL ASSOCIATION MEETING AT ST. JOHN.

As already stated the next meeting of the Maritime Medical Association will be held in St. John, July 22nd and 23rd.

The professional part of the proceedings will, with other attractions, be in the nature of two principal general discussions, and in the reading and discussion of papers and case reports.

The two subjects for discussion are: "The Early Manifestations of Pulmonary Tuberculosis," and "The Differential Diagnosis of Appendicitis," special attention being given to those affections and conditions which are not infrequently mistaken for appendicitis.

Papers will be given by Drs. M. A. Curry, G. M. Campbell, J. Stewart, N. E. McKay, G. C. Jones, T. J. F. Murphy, N. S. Fraser, of St. John's, McIntosh, McCully, G. A. B. Addy, A. B. Atherton, W. C. Crocket, F. F. Kelly, J. Ferguson, H. D. Johnston. Dr. Melvin will read a paper on the "Differential Diagnosis of Smallpox." Dr.

C. W. Wilson, Montreal, will give an account of "Orthopedic Surgery in Europe," from which country he has just returned. Dr. J. A. McKenzie will give a paper on "Borderland Mental Conditions." Dr. F. F. Kelly's paper will be on "Extra-uterine Gestation," and Dr. Crocket a case report on the same subject. Dr. N. E. McKay will read a paper on "Renal Calculus and Pyonephrosis."

It is quite evident, from the names of the gentlemen mentioned, that the professional interest in this meeting will be well maintained, and that no one can be present without being benefitted in many ways and pleased as well.

We have not been informed of the subject of the President's address, but from his known ability every one will expect something good from Dr. MacLaren, and it is quite certain there will be no disappointment in that respect. It is astonishing to what an extent the success of a meeting depends on the tact and ability of its presiding officer; we can therefore confidently expect that this meeting will be carried on harmoniously and expeditiously and in the best interests of all concerned.

THE MEETING AT ANTIGONISH.

Reference to the meeting of the Medical Society of Nova Scotia at Antigonish on the 1st and 2nd of July was made in our last issue, but we wish to remind our readers again of the dates. The programme has just been issued and evidently the gathering will prove profitable in every particular. "Tubercular Arthritis" will be discussed by Dr. J. Stewart on its pathology; Dr. A. E. Kendall, on its diagnosis, and Dr. N. E. McKay on its treatment. Among the papers promised are: "The Buried Absorbable Suture, its Value in Surgery," by Dr. H. O. Marcy of Boston, and "Treatment of Tuberculosis," by Dr. H. M. Neale, of Pennsylvania. The usnal reduced rates will be granted by the different railways and members must not forget their standard certificates to be obtained at the starting point.

Society Meetings.

ST. JOHN MEDICAL SOCIETY.

April 1st. Dr. Stewart Skinner, President, in the chair.

Pathological specimen. A large specimen of inguinal omental hernia was exhibited by Dr. Murray MacLaren.

Dr. G. A. B. Addy read a paper on "Antisepsis." The use of antiseptics in surgery was discussed and was, on the whole, considered to be useless and harmful. Strict attention to asepsis is essentially the important point to observe in surgical procedures.

April 8th. Dr. MacLaren reported the case of a pregnant woman suffering from tape-worm. The case was remarkable for the profound anæmia, which almost proved fatal and which quite disappeared after confinement and removal of the worm.

The President read a paper on "Minor Gynecology." The importance of attention to the general condition of patients suffering from minor gynecological troubles was pointed out, and in this way the avoidance of major operations rendered quite possible.

April 15th. Dr. Gray, Vice-President, in the chair.

Dr. F. H. Wetmore read a paper dealing with a number of cases observed at the Post Graduate Hospital, New York. Among the cases mentioned were ankylosis of elbow joint, flat foot, trephining of spinal column for depressed fracture and trephining for Jacksonian epilepsy.

April 22. Dr. S. Skinner, President, in the chair.

Dr. J. R. McIntosh showed a girl, aged 13 years, with congenital enlargement of thyroid gland.

Dr. McIntosh also referred to a new type, reading from left to right, which had been suggested as a relief to eye strain.

April 29. Dr. A. Pierce Crocket read a paper on "Chronic Suppuration of the Accessory Cavities of the Nose." (Published in this issue.)

On account of ill-health, Dr. Shaughnessy, secretary of the Society, resigned his office and Dr. McCully was elected to fill the position.

Much regret was expressed by the members at the cause of Dr. Shaughnessy's resignation and the best wishes of the Society for a speedy recovery were tendered him.

May 6th. Dr. Crawford exhibited an enlarged model of the ear and gave a demonstration on the anatomy and physiology of this organ.

May 13. Dr. Walker reported a case of measles with unusual premonitory symptoms, no catarrhal manifestations but symptoms suggesting small-pox until the measley rash appeared.

Dr. Walker also read an article by Dr. R. C. Court on "Truth and Falsehood in Medicine."

May 20th. Dr. Lunney read a paper on "Bullet Wounds" and reported a case of gun-shot wound of the abdomen which recovered without operation.

May 27th. Dr. Gray, Vice-President, in the chair. Annual meeting.

The Secretary reported that during the past year six new members had joined the Society. There had been 31 meetings.

The Treasurer reported that $108.80 had been expended during the year, leaving a balance on hand of $11.28.

The officers elected were:

President—Dr. J. H. Gray.

Vice-President—Dr. O. J. McCully.

Secretary—Dr. J. M. Barry.

Treasurer—Dr. J. Christie.

Librarian—Dr. Olding.

Room Committee—Drs. G. A. B. Addy, T. D. Walker and G. R. J. Crawford.

June 3rd. A special meeting was held to consider the arrearages of annual subscriptions of members, and it was finally decided that all arrearages, with the exception of the past year, be written off.

Personals.

Dr. J. B. Black, of Windsor, will leave this month on an extended visit to some of the larger hospitals on the Continent.

Dr. N. Pratt, of Lower Stewiacke, has been obliged to give up practice on account of ill-health. We hope that a prolonged rest will prove beneficial.

Dr. E. O. Hallett, and daughter, of Weymouth, while driving across the D. A. R. track collided with a hand-car, fracturing the little girl's arm and injuring the doctor, though fortunately not seriously.

Marriage has evidently been the greatest feature of this month, judging by the following number of the profession in this city, who have recently taken that step:

Dr. E. V. Hogan to Miss M. Carney, of Halifax.

Dr. A. E. Doull to Miss Mary Emily Burgess, of Milford, of New Hampshire.

Dr. Jane L. Heartz to Mr. A. J. Bell, of Halifax.

Dr. J. J. Doyle to Miss E. Brennan, of Salem, Mass.

Dr. T. E. Morris, of St. John was married on the 17th inst to Miss Ethel T. Finn, of the same city.

The NEWS extends its heartiest congratulations to all.

Dr. H. M. Hare recently returned from New York, where he was attending the Post Graduate Hospital.

The Antikamnia Chemical Company have issued a most valuable chart of "Diseases of the Nervous System and Muscles." The chart was arranged by **Dr. E. C. Hill,** and will prove a ready guide in diagnosis and treatment of the diseases mentioned. Every doctor may have a copy by appplying to the Antikamina Chemical Company, St. Louis.

Matters Medical

TO KEEP OFF MOSQUITOES.—The advice of one who has tried it (according to *Health*) is to throw a piece of alum, about the size of a marble, into a bowl of water, and wet the face and hands and any exposed part lightly with it. Not a mosquito will, it is asserted, approach you.

A correspondent of the *Lancet* describes a simple method of producing local anesthesia for small operations. A solution is prepared consisting of adrenalin chloride, 2 drachms; cocaine, 5 grains; and water, ½ ounce. Lint is folded into a pad of four layers, soaked in

the solution, and placed under a positive electrode. A large negative electrode is applied elsewhere, and a current of from 15 to 30 milliamperes is slowly induced and run for the space of from five to ten minutes. The surface may then be washed with ether, and any superficial operation performed painlessly and without loss of blood.

For Keeping Tools Bright and Free from Rust.—When out of use, brush them wtih a preparation made by stirring enough red or black mineral paint into crude petroleum to make the mixture of consistency easy to spread. This can be applied with a brush made of a piece of sheepskin tanned with the wool on, or with any ordinary brush. It will prevent rust, and may be rubbed off readily, leaving the face of the tool perfectly bright.—*Medical Times.*

A major and surgeon of the army stationed in the Philippines writes that recently, when the chief nurse of a small base hospital in Southern Luzon was sent away, there was a great struggle among the five nurses remaining for the vacant position, which meant a distinct increase in pay. Each one of the five came to the office of the surgeon in charge, to show cause why she should not be appointed chief nurse, and why none of the others was entitled to that distinction. The young Solomon in charge was "up against it," but gave the following decision: "Each one of you must write on a piece of paper her exact age, and send it sealed to me. The oldest woman will be made chief nurse." There is still a vacancy as chief nurse in a small base hospital in Southern Luzon.—*Medical Times.*

Notes.

Sanmetto in Urethritis and Enuresis.—Having had elegant results from the use of Sanmetto in genito-urinary diseases for quite a time, I am more fully convinced of its curative properties since having had a boy, aged twelve, call at my office, who had been suffering from an obstinate case of urethritis with enuresis. He stated that he had consulted two or three doctors, with no relief, and if he could be cured, cure him, and if not, not to give him anything. So I put him on the following

℞: Ol santali.....dr. ii.
Sanmetto q. s.....oz. iv.
Sig.....dr. i.

ever four hours, with rest in bed, and proper diet, and in ten days he was well and had no symptoms of either of the above troubles. Henceforth I shall know where to get a specific for such cases. I have always had good results from Sanmetto.

Brunswick, Ga. Wyatt C. Hatcher, M. D.

Skin Grafts Healed in Six Days, With Blood.—Arnold L., aged 24 years, German. Diagnosis, wound of the left cheek, the result of being thrown from a street car. Patient admitted to hospital March 10th, 1902. The wound was filled with gravel and dirt, and involved almost the entire side of the face. A space in the center of the cheek, 2 by 1½ inches, was completely denuded of skin. In this case it being desirable to have the

wound heal rapidly and with no evidence of scar, I determined to use grafts of normal skin sufficiently large to entirely cover the denuded surface. These grafts were secured from the patient's arms. The wound was dressed as in the other cases; the dressing being kept wet with bovinine. March 17th, the dressing was removed, and the wound was entirely healed, leaving no evidence of a scar whatever; but around the periphery there was some decided redness. This is probably the most rapid case of healing of this class on record.—T. J. Biggs, M. D.

Dysmenorrhea.—Chief among the symptoms for which the patient seeks relief in this condition is the pain preceding or accompanying the menstrual flow. This pain is often of so agonizing a nature as to incapacitate her from all work or even to render her life unbearable. In these cases there may be present a displacement of the uterus, usually anteflexion, disease of the ovaries, uterus or tubes. In many instances, however, no pathological lesions can be found, the pain being due to a neurgalic tendency, or to hypersensitiveness of the ovarain or uterine nerves, which manifests itself by painful sensations during the menstrual period, owing to the congestion of the tissues at this time, and may be accompanied by cramps of the uterine muscles. In this class of patients Hayden's Viburnum Compound is especially applicable, producing a marked sedative effect, relieving the pain and uterine colic, and if its use is persisted in it will gradually remove the hyperesthetic state and effect a permanent cure. If the dysmenorrhea be due to uterine or ovarian disease it will serve as a most valuable auxiliary to the local measures, by helping to remove the existing congestion and overcoming any spasmodic element, thus greatly shortening the period of treatment.

Iron as a Remedy.—Time out of mind, Iron has been leaned upon, as one of the special standbys in medicine, particularly as a builder and reconstructor. But unless Iron be given in proper form, one might as well give absorbent cotton, or chips or wet stones. When we desire to produce any increase in the number of red blood corpuscles, and to make them redder and richer with hemoglobin, we need to be sure of the form of iron that we are giving. The evidence has been accumulating these many years, that Manganese, in itself an admirable remedy, combined with Iron emphasizes the potency of both.

Dr. Gude, the great German chemist, contributed very definitely to the good of the profession, when he presented the product of long years of experimentation, and clinical experience, the Therapeutic product known as Pepto-Mangan (Gude).

Added to the many hundreds of clinical contributions, Dr. J. W. Frieser of Vienna, Austria, recently reports most favorably, and very forcibly, observing as follows:

"Pepto-Mangan contains Iron and Manganese combined with Peptone in the proper proportions, and in a readily digestible and absorbable form, so that the preparation can be completely utilized by the organism. As is well known, the peptones represent artificial predigested products, which when taken into the organism make no special demands upon the digestive functions, which in anæmic and chlorotic persons are usually weakened and impaired in action. This fact is the more important, since in these cases, the digestive process and the secretion of gastric juice is usually reduced, in consequence of which the nutrition is quite impaired, while frequently there is a condition of hyperacidity of the gastric juice. It has been most gratifyting to me to observe that during the use of Pepto-Mangan (Gude), which experience has taught me is particularly adapted in these maladies, it does not interfere with, or exert any disturbing effect upon the digestion. On the contrary, under its administration, the appetite and the digestion are stimulated in a very satisfactory manner.

"As a rule, during treatment with Pepto-Mangan the improvement in the constitution of the blood, as shown by physical examination, was accompanied by a beneficial effect upon the general condition and strength. The appearance and appetite of the patients improved visibly; the digestion and nutrition progressed favorably, and the patient felt better, happier, and more vigorous. Disturbances of the gastro-intestinal tract, such as pressure or pain over the stomach, nausea, disagreeable feeling of dullness, a diminution of appetite, constipation, congestions, etc., which are so frequent during the administration of other iron preparations, especially those of inorganic character, were scarcely ever observed during the use of Pepto-Mangan (Gude). On the contrary, in those cases in which there is a tendency to constipation, and a marked atony of the gastric functions my experience has led me to regard this remedy as especially useful and effective"—*Medical Mirror.*

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